Manulife

ATTENDING PHYSICIAN'S STATEMENT (DILATATION AND CURETTAGE)

Policy No.
Claim No. (For internal use)

To be completed by the Attending Physician at Insured's expense.

1. PATIENT'S PARTICULARS

Name of the Patient: ______________________________________ NRIC/Passport No: ______________

Date of Birth: _______________ Sex: ________ Admission No: ______________ Ward No: __________

Date of Admission: ___________________________ Date of Discharge: _________________________

2. DETAILS OF PATIENT'S CONDITION

In order for a claim under this policy to be paid, the following definition must be satisfied:

Dilatation and Curettage means an operation in which the cervix of the uterus is dilated and the endometrium of the uterus is scraped by a Medical Examiner to completely remove a cyst, tumour or any diseased tissue which is causing heavy bleeding. Dilatation and Curettage due to any of the following reasons is excluded:
(i)miscarriage
(ii)therapeutic or elective abortion
(iii)embedded intrauterine device or any other contraception means
(iv)bleeding after intercourse
(v)investigation of infertility
(vi)infection arising from sexually transmitted disease
(vii)Dilatation and Curettage for the purpose of obtaining a specimen for diagnostic purposes.

(a) Please describe the exact details of the patient's condition.

____

____

____

____

(b) Date you were first consulted for the condition: ________/ ________/ __________
dd mm yyyy

(c) What symptoms did the patient complain of when she first saw you for this condition?

____

____

____

____

(d) According to the patient, how long has she been experiencing these symptoms?

____

____

____

(e) For how long do you think the patient has actually experienced these symptoms?

____

____

(f) What was the diagnosis?

____

____

(g) Date when the condition was first diagnosed: ________/ ________/ _________
dd mm yyyy

(h) Date when the patient first became aware of the condition necessitating surgery: _____/ _____/ _____
dd mm yyyy

(i) Has the patient suffered any previous episodes of the underlying condition or any other condition leading to or relating to it? If yes, please give details. □ Yes □ No

____

____

____

____

(j) Are you aware of any members of the patient's close family who have suffered from this or any similar condition? If yes, please give details. □ Yes □ No

____

____

(k) Type of surgery or procedure performed: ____

(l) Reason(s) for surgery: ____

____

(m) Date of surgery: ________/ ________/ _________
dd mm yyyy

(n) Name and address of Hospital: ____

____

(o) Name and address of the Doctor who performed the surgery.

____

____

(p) Please give full details of all investigations performed in relation to this condition and their results.

____

____

____

(q) Please give details of the patient's habits in relation to alcohol, cigarette smoking and drug addiction, both past and present.

____

____

____

____

____

2. MEDICAL HISTORY

(a) If the patient was referred from a clinic or hospital, please state:

(i) Name of referral doctor: ____

(ii) Name of clinic/ hospital: ____

(iii) Date referred: ____

(b) Did the patient consult other doctors for this illness or its symptoms before she consulted you?

□ Yes □ No

If yes, please provide the name(s) and address(es) of the doctor(s) whom she consulted.

Name of Doctor	Name of Clinic/ Hospital and Address	Dates of Consultation

(c) Is the patient suffering or has suffered from any other significant illnesses? □ Yes □ No

If yes, please provide the following information to us.

Illness	Date of first Diagnosis	Name and Address of Attending Doctor

(d) Are you the patient's regular doctor? □ Yes □ No

If yes, since when? ________/ ________/ _________
dd mm yyyy

If no, please provide the name and address of the patient's regular doctor.

____

____

(e) Please give any other information which you feel would be helpful in assessment of the patient's claim.

____

____

____

____

____

____

Please enclose copies of specialist or hospital reports together with any tests or similar evidence to support the validity of the patient's claim.

Signature of Doctor

Date

Address & Official Stamp

Name and Qualification (printed)

Manulife (Singapore) Pte Ltd.
Reg. No. 198002116D
Main Office: 8 Cross Street #15-01, Manulife Tower, Singapore 048424
Tel: 67371221 Website: www.manulife.com.sg